

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07869

Reg. Dist. No. 290

07870

1. PLACE OF DEATH a. COUNTY <u>Albot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>London</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalville</u> 09X02	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u></u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u></u> Last <u>Askew</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>About 1997</u>
9. AGE (In years) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Thos. Asbury, Thurlock Md</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MILIARY TUBERCULOSIS</u> 019.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 31. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 JULY</u> , 19 <u>57</u> , to <u>22 JULY</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 JULY</u> , 19 <u>57</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>A. H. Owens, Jr.</u>		M.D. <u></u>	
PHYSICIAN'S NAME (Type) <u>A. H. OWENS, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/31/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Thurlock Md</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>J. J. Hampton Son, Hampton Md.</u>		24a. REC'D BY REGISTRAR <u>Federalville Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>N. H. Neerier</u>		DATE <u>7/31/57</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07870

7871

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bellevue	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS 332 N. 6th St Phila Pa	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Mem. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stewart Bailey		4. DATE OF DEATH 7-6-1957	
5. SEX Male	6. COLOR OR RACE COL.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levin Bailey		14. MOTHER'S MAIDEN NAME Bessie Denton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 332 N 6th St Phila Pa	
17. INFORMANT Levin Bailey son		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Chemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular DUE TO Renal crisis (c) 4-5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/26 , 19 57 , to 7/6 , 19 57 , that I last saw the deceased alive on 7/6 , 19 57 , and that death occurred at 2:45 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE K. Handicraft M.D.		ADDRESS (Street, city or town, state) Box 457, St. Michaels Md DATE SIGNED 7-9-57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-57	
22c. NAME OF CEMETERY OR CREMATORY Oocomac Cem.		22d. LOCATION (City, town, or county) (State) Oocomac, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Darrell Easton m.d.		24a. REC'D BY REGISTRAR 7/10/57 24b. REGISTRAR'S SIGNATURE N.A. Nevin	

CERTIFICATE OF DEATH

WYOMING STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

Form No. 1

RECEIVED
JUL 15 1957
BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1807871
07872 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>12</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>W</u> Last <u>Benson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1940</u>	
9. AGE (In years lost birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward W. Benson</u>				14. MOTHER'S MAIDEN NAME <u>Helen Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>RD #1</u>		17. INFORMANT Address <u>Edward W. Benson (father) Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Boeck's Sarcoid</u> <u>138.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Easton</u>				(County) <u>md.</u>		(State) <u>md.</u>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>Feb 10, 1957</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>214 S. Washington St. 161457</u>			
DATE SIGNED <u>7/18/57</u>							
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				<u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unionville cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton 16, md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Schiel</u>				ADDRESS <u>Easton, md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/18/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N.H. Neerick</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07873

CERTIFICATE OF DEATH

07872

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>425 South Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Virginia</u> Last <u>Copper</u>				4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>B</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19 10 46</u> yrs.	
9. AGE (In years last birthday) <u>46</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mangle</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wardley</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Spencer Taylor</u>			
14. MOTHER'S MAIDEN NAME <u>Irene Mowbray</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Samuel Copper</u>				17. INFORMANT <u>Samuel Copper</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4500</u> (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Left Hemiplegia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left Wrist in Cast from Fracture, March 30, 57 to Aug 16, 57</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>yes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Easton</u>				20g. (County) <u>Talbot</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>March 30, 1957</u> to <u>7-19, 1957</u> , that I last saw the deceased alive on <u>7-18, 1957</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.F. Buell</u>				DATE SIGNED <u>Easton Md.</u>			
PHYSICIAN'S NAME (Type) <u>M.F. Buell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Darby</u>				24a. REC'D BY REGISTRAR <u>7/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.A. Neenan</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of sanitarian	
28. Signature of health officer		29. Signature of coroner		30. Signature of jury	
31. Signature of medical examiner		32. Signature of pathologist		33. Signature of anatomist	
34. Signature of bacteriologist		35. Signature of virologist		36. Signature of epidemiologist	
37. Signature of public health nurse		38. Signature of health visitor		39. Signature of sanitarian	
40. Signature of health officer		41. Signature of coroner		42. Signature of jury	
43. Signature of medical examiner		44. Signature of pathologist		45. Signature of anatomist	
46. Signature of bacteriologist		47. Signature of virologist		48. Signature of epidemiologist	
49. Signature of public health nurse		50. Signature of health visitor		51. Signature of sanitarian	
52. Signature of health officer		53. Signature of coroner		54. Signature of jury	
55. Signature of medical examiner		56. Signature of pathologist		57. Signature of anatomist	
58. Signature of bacteriologist		59. Signature of virologist		60. Signature of epidemiologist	
61. Signature of public health nurse		62. Signature of health visitor		63. Signature of sanitarian	
64. Signature of health officer		65. Signature of coroner		66. Signature of jury	
67. Signature of medical examiner		68. Signature of pathologist		69. Signature of anatomist	
70. Signature of bacteriologist		71. Signature of virologist		72. Signature of epidemiologist	
73. Signature of public health nurse		74. Signature of health visitor		75. Signature of sanitarian	
76. Signature of health officer		77. Signature of coroner		78. Signature of jury	
79. Signature of medical examiner		80. Signature of pathologist		81. Signature of anatomist	
82. Signature of bacteriologist		83. Signature of virologist		84. Signature of epidemiologist	
85. Signature of public health nurse		86. Signature of health visitor		87. Signature of sanitarian	
88. Signature of health officer		89. Signature of coroner		90. Signature of jury	
91. Signature of medical examiner		92. Signature of pathologist		93. Signature of anatomist	
94. Signature of bacteriologist		95. Signature of virologist		96. Signature of epidemiologist	
97. Signature of public health nurse		98. Signature of health visitor		99. Signature of sanitarian	
100. Signature of health officer		101. Signature of coroner		102. Signature of jury	

RECEIVED
JUL 29 1957
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, 4 and 5 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07874

CERTIFICATE OF DEATH

07873

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u> 05822	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Corkran</u> Last <u>Corkran</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>6</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jessie Wright</u>				14. MOTHER'S MAIDEN NAME <u>Annie Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or status of service)		17. INFORMANT <u>Mrs. Eva C. Harrison, Bozman, Md.</u>		Address <u>Mrs. Eva C. Harrison, Bozman, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THROMBOSIS, BRANCH L. MIDDLE CEREBRAL ARTERY</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>23 July</u> , 19 <u>57</u> , to <u>25 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 July</u> , 19 <u>57</u> , and that death occurred at <u>9:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>A. H. Owens, Jr.</u> M.D. _____							
PHYSICIAN'S NAME (Type) <u>A. H. OWENS, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JR. ORDER CEM.</u>		22d. LOCATION (City, town, or county) <u>PRESTON</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry M. Hollis</u> ADDRESS <u>PRESTON, MD</u>				24a. REC'D BY REGISTRAR <u>DATE 7/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
CERTIFICATE OF DEATH

BUREAU V. S.

JUG 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 filed 7-11-57 at

CERTIFICATE OF DEATH

Reg. Dist. No. 07874

07886

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural St. Michaels</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Res. Vista Nursing Home</u>		d. STREET ADDRESS <u>117 S. Anson St.</u>	
3. NAME OF DECEASED (Type or print) <u>John Dean</u>		4. DATE OF DEATH <u>July 8 1957</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>Feb. 9, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Dean</u>		14. MOTHER'S MAIDEN NAME <u>Harriett M. Dean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>491-01-5905</u>	
17. INFORMANT <u>Mrs. Mary Love</u>		Address <u>Easton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adenocarcinoma prostate with</u> DUE TO (c) <u>widespread metastatic d.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cachexia, Generalized</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-15</u> , 195 <u>6</u> , to <u>7-6</u> , 195 <u>7</u> , that I last saw the deceased alive on <u>7-6</u> , 195 <u>7</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thos. M. Reese Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michaels Md</u>	
PHYSICIAN'S NAME (Type) <u>Thos M. Reese Jr.</u>		DATE SIGNED <u>7-9-57</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>July 11, 57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY, OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Easton</u> ADDRESS <u>Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 10 57</u>	24b. REGISTRAR'S SIGNATURE <u>Carl Smith</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 27 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07887

CERTIFICATE OF DEATH

Reg. Dist. No.

07875

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIO VISTA NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>BELLE</u> Last <u>FAIRBANKS</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 25, 1869</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
10. BIRTHPLACE (State or foreign country) <u>Talbot County - Md.</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
12. FATHER'S NAME <u>CHARLES HARRISON</u>		13. MOTHER'S MAIDEN NAME <u>SARAH E. CAWK</u>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		15. SOCIAL SECURITY NO. <u>NO</u>	
16. INFORMANT <u>HERBERT FAIRBANKS - ST. MICHAELS, MD.</u>		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour <u>o. p.</u> <u>19</u> p. m.		20b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 JUNE</u> , 1957, to <u>16 JULY</u> , 1957, that I last saw the deceased alive on <u>16 JULY</u> , 1957, and that death occurred at <u>7:45 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. A. [Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Box 487, St. Michaels, Md</u> <u>7-11-57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 18, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>ST. MICHAELS Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall</u>		ADDRESS <u>St. Michaels, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 19 57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PAU V. S.

1937

PAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07888

CERTIFICATE OF DEATH

Reg. Dist. No.

07876

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood, Rural				c. LENGTH OF STAY IN 1b 15 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood, Rural			
d. STREET ADDRESS				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Melvina Middle Foster Last Foster				4. DATE OF DEATH Month July Day 19 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/1867	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 8 Days 19 Hours 57 Min.	IF UNDER 24 HRS Months 8 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Frisco, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Riley Johnson				14. MOTHER'S MAIDEN NAME Mary Quidley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas L. Wallace, Sherwood, Maryland			
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic valvular heart disease DUE TO loss of compensation heart function Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) loss of compensation heart function DUE TO (c) loss of compensation heart function						INTERVAL BETWEEN ONSET AND DEATH 5 yrs 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1957 to July 19, 1957 , that I last saw the deceased alive on July 19, 1957 , and that death occurred at 11:00 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Tilghman, Md. DATE SIGNED July 20, 1957							
ACTUAL SIGNATURE GUY M REESER M.D.				PHYSICIAN'S NAME (Type) GUY M REESER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/57		22c. NAME OF CEMETERY OR CREMATORY Sherwood Cemetery		22d. LOCATION (City, town, or county) (State) Sherwood, Talbot Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Moore				ADDRESS Tilghman, Md.		24a. REC'D BY REGISTRAR 23 57	
24b. REGISTRAR'S SIGNATURE Tilghman							

RECEIVED

JUL 23 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY <u>Albany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Brookletts Ave.</u>				d. STREET ADDRESS <u>5200 Gwynn Oak Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORINNE W. FREILINGER</u>				4. DATE OF DEATH Month Day Year <u>July 15, 1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1878</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Adelaide Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. H. F. Chandler - 14 Brookletts Ave. Easton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/11/57</u> to <u>7/15/57</u> , 19 <u>57</u> that I last saw the deceased alive on <u>7/14/57</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Easton Md 7/15/57</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>				NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Leesburg, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons. Bacto 17th St.</u>				24a. REC'D BY REGISTRAR DATE <u>18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>M. J. Nevins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 18 1957

BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or reinterment.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDaniel		c. LENGTH OF STAY IN 1b 1 Wk.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1606 Holland St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mary E. Gibson			4. DATE OF DEATH Month 7 Day 11 Year 1957		
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1900		9. AGE (in years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Martin Fields			14. MOTHER'S MAIDEN NAME Alemia Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	17. INFORMANT William Gibson Address Wilmington, Del.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (c) Arteriosclerotic heart disease DUE TO cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Wilmington	(County) Del.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE E.C.H. Schmidt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12 July 57	
EXAMINER'S NAME (Type) E.C.H. Schmidt		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/15/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) Wilmington Del.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell, Easton, Md.		ADDRESS		24a. REC'D BY REGISTRAR 17 '57	24b. REGISTRAR'S SIGNATURE Al. Beach

PL 17-007

RECEIVED

07890

CERTIFICATE OF DEATH

07879

Reg. Dist. No. 190

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Lenora Pinett Green				4. DATE OF DEATH Month Day Year 7 127/57 19 57			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/26/56	
9. AGE (In years last birthday) 1 yrs		IF UNDER 1 YEAR Months Days Hours Min 4		IF UNDER 24 HRS Months Days Hours Min 4			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME George Murray				14. MOTHER'S MAIDEN NAME Wilsie Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Wilsie Green, Trappe Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Bacterial pneumonia INTERVAL BETWEEN ONSET AND DEATH 4-5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 23, 1957 to July 27, 1957 that I last saw the deceased alive on July 27, 1957 and that death occurred at from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold T. Webb M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 633 North St. Easton, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/57		22c. NAME OF CEMETERY OR CREMATORY Trappe Cemetery		22d. LOCATION (City, town, or county) (State) Trappe, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR AUG 6 1957	
24b. REGISTRAR'S SIGNATURE Mrs. N. H. Norris							

MEDICAL CERTIFICATION

TO POSTMORTEM ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

3 2 0187

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07891
CERTIFICATE OF DEATH

07880
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS			
c. LENGTH OF STAY IN 1b LIFE				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WALTON First A. Middle HAUSE Last				4. DATE OF DEATH JULY 15 Day 15 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 19 1883	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (State or foreign country) ST. MICHAELS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W.				14. MOTHER'S MAIDEN NAME ELIZABETH HIGGINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-20-7725		17. INFORMANT MRS. WILLIAM FELGENHOLER Address ST. MICHAELS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Carcinoma of prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 yr. 3 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3 July , 1957, to 15 July , 1957, that I last saw the deceased alive on 14 July , 1957, and that death occurred at 7:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Hause				DATE SIGNED Box 487, St. Michaels, Md. 7-16-57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 17, 1957		22c. NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) ST. MICHAELS, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE A. B. Harrison Address St. Michaels				24a. REC'D BY REGISTRAR 17 '57		24b. REGISTRAR'S SIGNATURE DeWitt	

RECEIVED

MAY 17 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08886

17876

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>4 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Chester</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>M.</u> Last <u>Hazleton</u>		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeremiah Hazleton</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Hazleton (wife)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Mary M. Hazleton (wife)</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>aur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>57</u> to <u>7/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/28</u> , 19 <u>57</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur B. Gil Jr.</u> M.D.		DATE SIGNED <u>7/28</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR B. GIL JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester</u>	22d. LOCATION (City, town, or county) (State) <u>Chester MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Goodrich</u>		24a. REC'D BY REGISTRAR <u>DATE 8/1/57</u>	24b. REGISTRAR'S SIGNATURE <u>M. W. Neenan</u>

RECEIVED

AUG 15 1957

BUREAU V. B.

07877

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kaston</u>				c. LENGTH OF STAY IN 1b <u>56 1/2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Irrin</u> Middle <u>D</u> Last <u>Hiestand</u>				4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/89</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Harry Hiestand</u>				14. MOTHER'S MAIDEN NAME <u>Alice Dehuff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes, give war or dates of service</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Dorothy W. Hiestand (wife)</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u> DUE TO <u>Coronary Artery Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1.5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1956</u> , to <u>July 1957</u> , that I last saw the deceased alive on <u>July 7, 1957</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. H. Hest</u> M.D.				ADDRESS (Street, city or town, state) <u>Box 457, St. Michaels, Md</u> DATE SIGNED <u>7-10-57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u>				ADDRESS <u>Balt. 12, Md</u>		24a. REC'D BY REGISTRAR DATE <u>7/12/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. H. Newen</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07882

07892

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford	
c. LENGTH OF STAY IN 1b 4 yrs		d. STREET ADDRESS DIVISION ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert (none) Macindoe		4. DATE OF DEATH Month 7 Day 23 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/01
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Macindoe		14. MOTHER'S MAIDEN NAME Mary Stewart Neilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Wife		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rectal Hemorrhage 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinomatosis DUE TO (c) CARCINOMA OF Rt. Lung			INTERVAL BETWEEN ONSET AND DEATH 7 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. , 1956, to July , 1957, that I last saw the deceased alive on July 23 , 1957, and that death occurred at 10:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Terr M.D.		ADDRESS (Street, city or town, state) 31 Goldsboro St. Easton Md.	
PHYSICIAN'S NAME (Type) Norman Terr		DATE SIGNED 7/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 25, 1957	22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	22d. LOCATION (City, town, or county) (State) Oxford, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman		24. REGISTRAR'S SIGNATURE N. H. Newman	

BUREAU V. 31

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07883

07878

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville - RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First Middle Last <u>Mae Morris</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 21 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Nelson Faulkner</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Carroll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Mary M. Thomas (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of leg</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Diabetes mellitus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>7/23/1957</u> that I last saw the deceased alive on <u>7/23/1957</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Cox</u>		M.D. <u>Easton Md</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Butler Bur. by J. Butler, Centerville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/26/57</u>	
24b. REGISTRAR'S SIGNATURE <u>N.A. Neer</u>			

RECEIVED

JUL 29 1957

BUREAU V. S.

07893

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford				c. LENGTH OF STAY IN 1b 10 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS Oxford			
3. NAME OF DECEASED (Type or print) JANE LEVIS PRITCHARD				4. DATE OF DEATH Month JULY Day 5 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1899	9. AGE (In years last birthday) 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Penna.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Griffydd D. Griffiths				14. MOTHER'S MAIDEN NAME Mary Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Rev. D. T. Pritchard		Address Oxford, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STROKE DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 55 to July 5 , 19 57 , that I last saw the deceased alive on July 5 , 19 57 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald F. Bartley				M.D. 9 N. HANSON ST. EASTON		DATE SIGNED July 5, 1957	
PHYSICIAN'S NAME (Type) Dr. D. F. Bartley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		22d. LOCATION (City, town, or county) (State) Oxford, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE 7/9/57	
				24b. REGISTRAR'S SIGNATURE N.H. Newnam			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 of this certificate will be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V 3

JUL 10 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7879

CERTIFICATE OF DEATH

07885-5910

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>507 High St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Rich</u> Last <u>Rich</u>		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.W.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Emory</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Richard Rich (Grandson)</u>	
17. INFORMANT <u>Richard Rich (Grandson)</u>		Address <u>Denton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>145 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma left tonsil</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred on <u>4:20 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>219 S. Westington St. Easton 16, Maryland.</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		DATE SIGNED <u>28 July 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Aug 1</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	22d. LOCATION (City, town, or county) (State) <u>Denton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. McCreary</u> ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR DATE <u>7/31/57</u>	24b. REGISTRAR'S SIGNATURE <u>N.H. Neekin</u>

BUREAU V. S.

1057

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07880

CERTIFICATE OF DEATH

07886

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funlock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1st St</u>	
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>Rivers</u> Middle <u>Rivers</u> Last		4. DATE OF DEATH <u>July</u> Month <u>29</u> Day <u>1957</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7, 1907</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u> Hours <u>19</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Rivers</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>2-66-01-0181</u>	
17. INFORMANT <u>Bessie Rivers (wife)</u>		Address <u>Funlock</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDITIS</u> DUE TO (b) <u>ACTIVE RHEUMATIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Hour <u>o. 3.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that I attended the deceased from <u>16 July, 1957</u> to <u>29 July 1957</u> , that I last saw the deceased alive on <u>29 July</u> <u>1957</u> , and that death occurred at <u>Funlock</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. H. Owens Jr.</u>		DATE SIGNED <u>7/30/57</u>	
PHYSICIAN'S NAME (Type) <u>A. H. OWENS JR.</u>		ADDRESS (Street, city or town, state) <u>Funlock Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-3-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>	22d. LOCATION (City, town, or county) <u>Funlock</u> (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson Son Federalburg Md.</u>		24a. REC'D BY REGISTRAR <u>7/31/57</u> 24b. REGISTRAR'S SIGNATURE <u>N. H. Owens</u>	

RECEIVED

AUG 2 1957

BUREAU V. 2

Reg. Dist. No. 07887

07894

Reg. Dist. No.

07887

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BLU VISTA HOME		d. STREET ADDRESS NONE	
3. NAME OF DECEASED (Type or print) EDWARD STROUD ROWENS		4. DATE OF DEATH Month JULY Day 5 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 18, 1880
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATION AGENT - RET. RAILROAD		12. BIRTHPLACE (State or foreign country) MARYLAND	
13. CITIZEN OF WHAT COUNTRY? U.S.A.		14. FATHER'S NAME THOMAS JAMES ROWENS	
15. MOTHER'S MAIDEN NAME MARY ELIZABETH STROUD		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO	
17. SOCIAL SECURITY NO. NONE		18. INFORMANT MRS. MARGARET M. ROWENS, QUEENSTOWN MD	
19. ADDRESS NONE		20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) 5 yrs (c)	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. INTERVAL BETWEEN ONSET AND DEATH 1 wk	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
25. TIME OF INJURY Hour 19 o. m. 5 p. m.		26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that I attended the deceased from 27 June, 1957 , to 5 July, 1957 , that I last saw the deceased alive on 5 July, 1957 , and that death occurred at 1:00 PM , from the causes and on the date stated above.		30. ADDRESS (Street, city or town, state) St. Michaels, Maryland	
31. ACTUAL SIGNATURE R. Lane Worth		32. DATE SIGNED 7-8-57	
33. PHYSICIAN'S NAME (Type) W. Hampton Currell		34. ADDRESS Easton, Md.	
35. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		36. DATE THEREOF 7/8/57	
37. NAME OF CEMETERY OR CREMATORY SPRING HILL CEMETERY		38. LOCATION (City, town, or county) (State) EASTON MARYLAND	
39. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Currell		40. ADDRESS Easton, Md.	
41. REC'D BY REGISTRAR DATE JUL 11 1957		42. REGISTRAR'S SIGNATURE Paul	

RECEIVED

JUL 11 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07888

78831

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Deale</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XXXXXXXXXXXX 07X 22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				d. STREET ADDRESS <u>Federalburg RFD #1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Baby Bay</u> Middle <u>Sims</u> Last <u>Sims</u>				4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-26-57</u>	9. AGE (In years last birthday) yrs <u>12</u>	IF UNDER 1 YEAR Months <u>12</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u>12</u> Min <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Mark Sims</u>				14. MOTHER'S MAIDEN NAME <u>Eileen McNeal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mark Sims</u> Address <u>Hurdock Ind</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature Twin</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>17 1/2 hrs</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 5.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/26</u> , 19 <u>57</u> , to <u>7/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/26/57</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. E. Cox</u> M.D. <u>Easton Ind</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>R. E. Cox</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Washell</u> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>N. A. Neer</u>	
DATE <u>7/29/57</u>							

RECEIVED

AUG 8 1957

BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17882

CERTIFICATE OF DEATH

07889

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSISSIPPI b. COUNTY DRAW	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DRAW	
d. NAME OF HOSPITAL (If not in hospital, give street address) Memorial Hosp		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) FRED First Middle Last Thomas		4. DATE OF DEATH Month 7 Day 4 Year 1957	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Unknown	12. CITIZEN OF WHAT COUNTRY? ?
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Laura Betty D. ME		ADDRESS (Street, city or town, state) Easton DATE SIGNED 7-4-57	
PHYSICIAN'S NAME (Type) Leon W. Henry Cook			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY City Morgue	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leon W. Henry Cook		24a. REC'D BY REGISTRAR DATE 7/8/57	24b. REGISTRAR'S SIGNATURE N. H. Newman

BUREAU V. S.

JUL 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07895

CERTIFICATE OF DEATH

07890
970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Trappe				c. LENGTH OF STAY IN 1b 13 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First BENNETT Middle TODD Last				4. DATE OF DEATH Month July Day 30 , Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov .16, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired Farmer		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Willard C. Todd				14. MOTHER'S MAIDEN NAME Willeminah Willoughby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-30-7611A		17. INFORMANT Address Mrs Retta Todd Trappe, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio sclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 18, 1957 to July 30, 1957 , that I last saw the deceased alive on July 9, 1957 , and that death occurred at 7 A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Paul Knotts M.D.				DATE SIGNED Denton Md			
PHYSICIAN'S NAME (Type) Dr. E. Paul Knotts				Denton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Kemp Burial Ground		22d. LOCATION (City, town, or county) (State) Trappe, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE 8/1/57	
				24b. REGISTRAR'S SIGNATURE M. H. Newnam			

RECEIVED

AUG 9 1937

BUREAU V. S.

MEDICAL CERTIFICATION

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Cremated	7/5/57	Shelbrook Cemetery	Wilkesboro	N.C.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
J. J. Thompson		Son Federalburg, Md.	DATE 2/8/57	W. H. Neer

BUREAU V. M.

JUL 18 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Filed 8-13-57 et
CERTIFICATE OF DEATH

C7884

07892

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 216 DANTON ROAD	
3. NAME OF DECEASED (Type or print) First JAMES Middle F. Last WALKER		4. DATE OF DEATH Month JULY Day 25 Year 1957	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 25-1870
9. AGE (In years last birthday) 87 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) minister	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Walker		14. MOTHER'S MAIDEN NAME Grace Herbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edith White Daughter 2319 Maden Rd		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. V. A 322.5 DUE TO Arteriosclerosis, generaliz Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. ft. Month 19 Day 19 Year 1957 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Balt. Md		(County) (State)	
21. I certify that I attended the deceased from 7/17 , 19 57 , to 7/25 , 19 57 , that I last saw the deceased alive on 7/25 , 19 57 , and that death occurred at 8:50 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Easton Md DATE SIGNED 13 Conf			
ACTUAL SIGNATURE 13 Conf M.D. Easton Md			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7-30-57	22c. NAME OF CEMETERY OR CREMATORY Gloucester	22d. LOCATION (City, town, or county) (State) Gloucester Va.
23. FUNERAL DIRECTOR'S SIGNATURE James B. Danwell		24a. REC'D BY REGISTRAR DATE 7-30-57	
24b. REGISTRAR'S SIGNATURE N.H. Neer			

U. S. A.

1957

511

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07896

CERTIFICATE OF DEATH

07893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 15 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R 4 Box 78				e. STREET ADDRESS Rt 4 - Box 78			
3. NAME OF DECEASED (Type or print) First Lula Middle Wilson Last Wilson				4. DATE OF DEATH Month 7 Day 19 Year 1957			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?	
9. AGE (In years last birthday) 91 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give rank or dates of service)			
16. SOCIAL SECURITY NO. —				17. INFORMANT Joseph Wilson Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 11/18/56 , 19 56 , to 7/17/57 , 19 57 , that I last saw the deceased alive on 11/26/56 , 19 56 , and that death occurred at M , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE B. G. G. M.D.				DATE SIGNED 2-20-57			
PHYSICIAN'S NAME (Type)				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 7/23/57				22c. NAME OF CEMETERY OR CREMATORY Ivytown Cemetery			
22d. LOCATION (City, town, or county) (State) Easton Rt. 4, Md.				23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell ADDRESS 426 Dover Street			
24a. REC'D BY REGISTRAR 1566				24b. REGISTRAR'S SIGNATURE 1957			

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

AUG 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07894

07885

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Boyman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Benjamin Wilson Sr.</u>		4. DATE OF DEATH <u>July 21 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30 1883</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dupont Co. Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James B Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Letitia Bradshaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>wife</u>		Address <u>Boyman Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1042 yrs.</u> MINUTES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>541.0 G.I. Bleeding from Duodenal Ulcer</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 July 1957</u> to <u>21 July 1957</u> , that I last saw the deceased alive on <u>21 July 1957</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Owens, Jr.</u>		ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>July 21, 1957</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balt.</u>		24a. REC'D BY REGISTRAR <u>DATE 7/23/57</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. N. H. Lewis</u>	

CERTIFICATE OF DEATH

BUREAU V. 3

JUL 24 1957

RECEIVED